CALIFORNIA HEALTH BENEFIT EXCHANGE
STATE LEGISLATIVE REPORT
BOARD MEETING UPDATE

Last updated: October 1, 2012

BILL NUMBER	SUMMARY	BILL STATUS
AB 43 (Monning) **Version:** As amended, May 27, 2011	**Medi-Cal: eligibility expansion** Effective January 1, 2014, this bill would expand Medi-Cal coverage to persons with income not exceeding 133% of the federal poverty level. Among other provisions, this bill would require the DHCS to establish eligibility for Medi-Cal benefits for any person who meets the requirements of a new Medicaid eligibility category added by the Affordable Care Act (ACA). This bill is related to SB 677 (Hernandez).	**Location:** Senate Inactive File
AB 52 (Feuer) **Version:** As amended, June 1, 2011	**Health care coverage: DMHC and CDI rate approval** Among other provisions, this bill would require that the DMHC and the CDI prior approve all health plan and insurance rate changes and rates for new products, and would prohibit the DMHC and the CDI from approving any rate or rate change that is found to be excessive, inadequate, or unfairly discriminatory. The bill would also authorize the DMHC and the CDI to approve, deny, or modify any proposed rate or rate change, as well as authorize the DMHC and the CDI to review any rate or rate change that went into effect between January 1, 2011 and January 1, 2012, and to order refunds subject to this bill's provisions.	**Location:** Senate Inactive File
AB 174 (Monning) **Version:** As enrolled, September 11, 2012	**CA Health and Human Services Automation Fund** Establishes the California Health and Human Services Automation Fund (Fund), in the State Treasury, to consist of moneys appropriated to various specified health and human services information technology (IT) projects, and requires the moneys in the Fund to be available upon appropriation by the Legislature for expenditure by the Office of Systems Integration (OSI). The bill permits the Employment Development Department (EDD) and the Franchise Tax Board (FTB) to share information and develop data interfaces with the Exchange for purposes of enabling the Exchange to make eligibility determinations and comply with certain federal requirements.	**Chapter Number 815, Statutes of 2012**

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BILL NUMBER	SUMMARY	BILL STATUS
AB 714 (Atkins) **Version:** As amended, June 30, 2011	**California health benefit exchange: eligibility disclosure** This bill would require the DHCS, the CDPH, and the MRMIB to provide two specified notices of potential health care eligibility through the Exchange to every individual enrolled in, or ceased to be enrolled in, specified publicly-funded state health care programs. The bill would also require certain hospitals, when billing, to include additional disclosures regarding health care coverage through the Exchange.	**Location:** Senate 2 year
AB 792 (Bonilla) **Version:** As enrolled, September 11, 2012	**California Health Benefit Exchange: notice requirements** This bill would require a court, upon the filing of a petition for dissolution of marriage, nullity of marriage, or legal separation, to provide a notice informing the petitioner and respondent that they may be eligible for reduced-cost coverage through the Exchange or no-cost coverage through Medi-Cal. The bill would also require a court to provide such a notice to a petition for adoption. The notice will include information regarding obtaining coverage through those programs and would require the notice to be developed by the Exchange. This bill would also require specified health plans and insurers to provide to individuals who cease to be enrolled in individual coverage and to individuals who lose coverage under an employer-sponsored group plan a notice informing those individuals that they may be eligible for reduced-cost coverage through the Exchange or no-cost coverage through Medi-Cal. The bill would require the notice to include information regarding obtaining coverage through those programs, and be developed by the Department of Managed Health Care and the Department of Insurance.	**Chapter Number 851, Statutes of 2012**

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BILL NUMBER	SUMMARY	BILL STATUS
AB 1083 (Monning) Version: As enrolled, September 11, 2012	**Small Group Market** Among other provisions, this bill would change the definitions and criteria related to eligible employees and rating periods, and, for plan years commencing on or after January 1, 2014, risk adjustment factors, age categories, and health status-related factors, as specified. The bill would prohibit the use of risk adjustment factors and preexisting condition provisions on and after January 1, 2014. With regard to premium rates charged by a health plan on and after January 1, 2014, the bill would only allow rates to be varied with respect to family rating, rating area, and age, as specified. The bill would change the definition of small employer and would require employer contribution requirements to be consistent with the ACA. With regard to the sale of plan contracts or health benefit plans, the bill would prohibit specified persons or entities from encouraging or directing small employers to seek coverage from another plan or the voluntary purchasing pool established under the Exchange. The bill would also require all policies of individual health insurance that are offered, sold, renewed, or delivered on or after January 1, 2014, to provide coverage for essential health benefits, as defined, except as specified.	**Chapter Number 852, Statutes of 2012**

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BILL NUMBER	SUMMARY	BILL STATUS
AB 1453 (Monning) **Version:** As enrolled, September 12, 2012	**Essential health benefits: coverage** This bill would require an individual or small group health plan or health insurance policy issued, amended, or renewed on or after January 1, 2014, to cover essential health benefits, which would be defined to include the health benefits covered by particular benchmark plans. The bill would authorize a plan or insurer to place scope and duration limits on those benefits, except as specified, provided that the limits are not greater than the limits imposed by the benchmark plans and would generally prohibit a plan or insurer from making substitutions of the benefits required to be covered. The bill would specify that these provisions apply regardless of whether the contract or policy is offered inside or outside the Exchange but would provide that they do not apply to grandfathered plans or plans that cover only excepted benefits, as specified. The bill would prohibit a health plan or health insurer, when offering, selling, or marketing a plan contract or policy, from indicating or implying that the contract or policy covers essential health benefits unless the contract or policy covers essential health benefits as provided in the bill. This bill is related to SB 951 (Hernandez).	**Chapter Number 854, Statutes of 2012**

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BILL NUMBER	SUMMARY	BILL STATUS
AB 1461 (Monning) **Version:** As enrolled, September 11, 2012	**Individual Health Care coverage** This bill would requires a plan or insurer, on and after October 1, 2013, to offer, market, and sell all of the plan's health benefit plans that are sold in the individual market to all individuals and dependents in each service area in which the plan provides or arranges for the provision of health care services, with coverage effective on or after January 1, 2014, but would require plans and insurers to limit enrollment in individual health benefit plans to specified open enrollment and special enrollment periods. The bill would prohibit these plans from imposing any preexisting condition upon any individual. Commencing January 1, 2014, the bill would prohibit a plan or insurer from conditioning the issuance or offering of individual health benefit plans on any health status-related factor, as specified, and would authorize plans and insurers to use only age, geographic region, and whether the plan covers an individual or family for purposes of establishing rates for individual health benefit plans, as specified. The bill would require a health care service plan or health insurer to issue a specified notice at least 60 days prior to the renewal date of an individual grandfathered health plan to all subscribers and policyholders of the plan. The bill would enact other related provisions and make related conforming changes. This bill is related to SB 961 (Hernandez).	**VETOED**
AB 1580 (Bonilla) **Version:** As enrolled, August 30, 2012	**Health care: eligibility: enrollment** This bill would make technical and clarifying changes to provisions enacted in AB 1296 (Bonilla-2011), relating to revised and simplified applications for state health subsidy programs. The bill clarifies that a requirement granting an applicant benefits during the time the application for eligibility is being reviewed, also known as presumptive eligibility or PE, is not intended to grant a right to PE beyond what is currently required. The bill also clarifies that when the applicant appears to be eligible for Medi-Cal under the aged, blind, or disabled category, but is determined to be ineligible after a screening for the new Modified Adjusted Gross Income category, the application will be forwarded to the Medi-Cal program for further determination.	**Chapter Number 856, Statutes of 2012**

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BILL NUMBER	SUMMARY	BILL STATUS
AB 1636 (Monning) **Version:** As amended, June 25, 2012	**California Health Benefit Exchange: health and wellness programs** This bill would require the DMHC, in collaboration with the DOI, HBEX, and the DPH, to convene a special committee consisting of specified members to review and evaluate health and wellness incentive and rewards programs offered by health care service plans, health insurers, and employers. The bill would require the committee to evaluate these programs for effectiveness based upon scientific evidence and to examine the extent to which these programs may result in specified discrimination. The bill would require the committee to meet publicly and would require the first meeting to be conducted no later than March 30, 2013.	**Location:** Senate Appropriations
AB 1761 (Perez) **Version:** As enrolled, September 11, 2012	**California Health Benefit Exchange: unfair business practices** This bill prohibits an individual or entity from holding himself, herself, or itself out as representing, constituting, or otherwise providing services on behalf of the Exchange unless that individual or entity has a valid agreement with the Exchange to engage in those activities.	**Chapter Number 876, Statutes of 2012**
AB 1766 (Bonilla) **Version:** As amended, April 9, 2012	**California Health Benefit Exchange: small business health options program** This bill would prohibit the Small Business Health Options Program from informing an eligible employee or dependent thereof about, or screening that employee or dependent for eligibility for, a premium tax credit, the Medi-Cal program, the Healthy Families Program, or any other state or local public program.	**Location:** Assembly Health

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BILL NUMBER	SUMMARY	BILL STATUS
AB 1809 (Monning) **Version**: As amended, May 1, 2012	**Health Care Coverage** The DMHC and the CDI are required to maintain a joint senior level work group to ensure clarity for consumers about who enforces patient rights and consistency in the regulations in these departments. This bill would delete provisions that require the work group to submit findings to the Director and the Commissioner, and the Director and Commissioner to submit a report to the Legislature every year for 5 years, beginning January 1, 2004. Existing federal law regarding medical loss ratio requires health plans and insurers to provide rebates to current and former enrollees in a lump sum check, premium credit, or other specified reimbursement methods. This bill would make these provisions of federal law applicable to a health plan and health insurer with respect to the method by which it provides premium rebates to current and former enrollees or insureds, as specified. The bill would require a health care service plan and health insurer to make a good faith effort to locate its former enrollees or insureds that are entitled to the rebate. This bill would create the Health Care Coverage Information, Enrollment, and Eligibility Assistance Account within the California Health Trust Fund. The bill would require a health care service plan and health insurer that is unable to locate its former enrollees or insureds who are entitled to a premium rebate to cause those rebate funds to be deposited in the account to be continuously appropriated for purposes of distributing funding for health care coverage information, enrollment, and eligibility assistance.	**Location:** Assembly Appropriations

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BILL NUMBER	SUMMARY	BILL STATUS
AB 1846 (Gordon) **Version:** As enrolled, September 6, 2012	**Consumer operated and oriented plans (CO-OPs)** This bill would authorize the Director of the DMHC to issue a health plan license, and the Insurance Commissioner to issue a certificate of authority, to a consumer operated and oriented plan (CO-OP) established consistent with PPACA, as specified. The bill would specify that a CO-OP issued a license or a certificate of authority is subject to all other provisions of law relating to health plans or insurance, respectively, and would further specify that a CO-OP insurer and any solvency loan obtained by the CO-OP pursuant to PPACA are subject to certain requirements imposed on mutual insurers. The bill would authorize the director and the commissioner to request documentation relating to a CO-OP's solvency or start-up loan. The bill would prohibit a CO-OP from converting or selling to a for-profit or nonconsumer-operated entity after receiving a solvency loan, would require a CO-OP to comply with specified governance standards, and would authorize the commissioner to revoke a CO-OP insurer's certificate of authority, for violating those prohibitions. The bill would authorize the Department of Insurance to enact regulations implementing these provisions with respect to CO-OP insurers and would enact other related provisions.	**Chapter Number 859, Statutes of 2012**
AB 1869 (Perez) **Version:** As enrolled, July 24, 2012	**Office of the Patient Advocate: federal veterans health benefits** This bill adds federal veterans' health benefits to the example of the type of information and assistance regarding public programs that the Office of Patient Advocate (OPA) shall do in order to assist in implementing federal health reform in California commencing, January 1, 2013.	**Chaptered July 24, 2012** **Chapter Number 167**

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BILL NUMBER	SUMMARY	BILL STATUS
AB 1921 (Hill) **Version:** As amended, April 23, 2012	**Health insurance: transitional reinsurance program** This bill, until January 1, 2018, would establish a transitional reinsurance program for health plans, and require participation by health plans and health insurers. The bill would require the Insurance Commissioner to select a reinsurance entity, which would collect payments from contributing health plans and the United States Department of Health and Human Services on behalf of self-insured group plans and pay claims, as specified. The bill would authorize the Commissioner and the Director the DMHC to take various actions to implement the program. The bill would require contributing entities to make payments to the reinsurance entity no earlier than October 1, 2013, and would provide for the reinsurance entity to pay claims to a reinsurance-eligible recipient no earlier than January 1, 2014, with payments and claims to cease on December 31, 2016, except for necessary adjustments.	**Location:** Senate Health
AB 2034 (Fuentes) **Version:** As enrolled, September 6, 2012	**Medical Care: genetically handicapping conditions** This bill would require the DHCS to prepare a report on the coverage needs of the population served by the GHPP after the implementation of the PPACA. This bill would require the report to address, among other things, preservation of the availability of wrap-around services that would otherwise not be available through the PPACA and the extent to which a person with genetic amyotrophic lateral sclerosis will continue to have unmet medical needs after implementation of the PPACA. This bill would require the department to submit the report to the relevant fiscal and policy committees of the Legislature by January 1, 2015.	**VETOED**
AB 2508 (Bonilla) **Version:** As enrolled, September 11, 2012	**Public Contracts: public health agencies** AB 2508 would prohibit state agencies that manage specified public benefit programs from contracting for call center services outside the state.	**Chapter Number 824, Statutes of 2012**

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SB 35 (Padilla) **Version:** As enrolled, September 11, 2012	**Voter Registration Agencies** This bill would require the California Health Benefit Exchange, no later than July 1, 2014, to implement a process and the infrastructure to allow a person who applies online for service or assistance, or who submits a recertification, renewal, or change of address form relating to the voter registration service or assistance online, to submit an affidavit of voter registration electronically on the Internet Web site of the Secretary of State.	**Chapter Number 505, Statutes of 2012**
SB 615 (Calderon) **Version:** As enrolled, September 7, 2012	**Health plans: accident and health agents: licensure** This bill would prohibit a multiple employer welfare arrangement (MEWA) from offering, issuing, selling, or renewing health care coverage benefits unless the MEWA discloses whether the benefits constitute minimum essential coverage in its marketing materials.	**Chapter Number 266, Stats of 2012**
SB 677 (Hernandez) **Version:** As amended, May 23, 2011	**Medi-Cal: eligibility** This bill would provide, to the extent required by federal law, that the DHCS may not apply an assets or resources test for purposes of determining eligibility for Medi-Cal or under a Medi-Cal waiver, except as specified. This bill would also require, to the extent required by federal law, the DHCS to use the modified adjusted gross income of an individual, or the household income of a family, if applicable, for the purposes of determining income eligibility for Medi-Cal or under a Medi-Cal waiver, except as specified. The bill would provide that these provisions shall become operative on January 1, 2014. Because each county is responsible for making Medi-Cal eligibility determinations, the bill would increase the duties of county officials and would thereby impose a state-mandated local program.	**Location:** Assembly Inactive File

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BILL NUMBER	SUMMARY	BILL STATUS
SB 703 (Hernandez) **Version:** As amended, June 25, 2012	**Health care coverage: Basic Health Program** This bill would establish in State government a Basic Health Program (BHP), to be administered by the Department of Health Care Services (DHCS) to provide coverage to eligible individuals. The bill would require the DHCS to enter into a contract with the United States Secretary of Health and Human Services (HHS) to implement the BHP, and would set forth the powers and duties of the DHCS regarding this program. The bill would require the DHCS to begin enrollment in the program on January 1, 2014, and would create the Basic Health Program Trust Fund (BHP Trust Fund) for this purpose. The bill would require the DHCS to negotiate contracts with health plans to provide, or pay for, benefits under the BHP. The bill contains other related provisions of the DHCS regarding this program. The bill would also require the DHCS to begin enrollment in the program on January 1, 2014, and would create the Basic Health Program Trust Fund (BHP Trust Fund) or this purpose. The bill would require the DHCS to negotiate contracts with health plans to provide, or pay for, benefits under the BHP. The bill contains other related provisions.	**Location:** Assembly Appropriations
SB 951 (Hernandez) **Version:** As enrolled on September 6, 2012	**Health care coverage: essential health benefits: benchmark plan, Kaiser** Requires an individual or small group health plan or insurance policy issued, amended to cover essential health benefits, which would be defined to include the health benefits covered by particular benchmark plans. The bill would authorize a plan or insurer to place scope and duration limits on those benefits, except as specified, provided that the limits are not greater than the limits imposed by the benchmark plans and would generally prohibit a plan or insurer from making substitutions of the benefits required to be covered. The bill would specify that these provisions apply regardless of whether the contract or policy is offered inside or outside the Exchange but would provide that they do not apply to grandfathered plans or plans that- cover only excepted benefits, as specified. The bill would prohibit a health plan or health insurer, when offering, selling, or marketing a plan contract or policy, from indicating or implying that the contract or policy covers essential health benefits unless the contract or policy covers essential health benefits as provided in the bill. Clarifies that these provisions would only be implemented to the extent essential health benefits are required pursuant to PPACA. This bill is related to AB 1453 (Monning).	**Chapter Number 866, Statutes of 2012**

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BILL NUMBER	SUMMARY	BILL STATUS
SB 961 (Hernandez) **Version:** As enrolled, September 6, 2012	**Individual Market Reform** Requires a plan or insurer, on and after October 1, 2013, to offer, market, and sell all of the plan's health benefit plans that are sold in the individual market to all individuals and dependents in each service area in which the plan provides or arranges for the provision of health care services, with coverage effective on or after January 1, 2014. Requires plans and insurers to limit enrollment in individual health benefit plans to specified open enrollment and special enrollment periods. Prohibits these health benefit plans from imposing any preexisting condition upon any individual. Would prohibit a plan or insurer from conditioning the issuance or offering of individual health benefit plans on any health status-related factor and would authorize plans and insurers to use only age, geographic region, and whether the plan covers an individual or family for purposes of establishing rates for individual health benefit plans. Requires a plan or insurer to issue a specified notice at least 60 days prior to the renewal date of an individual grandfathered health plan to all subscribers and policyholders of the plan. Authorizes the DMHC, until January 1, 2015, to waive or modify those requirements for purposes of compliance with PPACA, as specified. Prohibits the premium for those policies and contracts from exceeding the premium for a specified plan offered in the individual market through the California Health Benefit Exchange in the rating area in which the individual resides. This bill is related to AB 1461 (Monning).	**VETOED**

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BILL NUMBER	SUMMARY	BILL STATUS
SB 970 (De Leon) **Version:** As enrolled, September 6, 2012	**Horizontal Integration** This bill would provide for the transmittal to a county human services department of information about an applicant initially applying for, or renewing, health care coverage using the single state application, if the applicant consents to have his or her application information used to simultaneously initiate applications for CalWORKs and CalFresh, for initiation of the application. Authorizes CHHS to phase in implementation of these provisions under certain circumstances. Requires CHHS to convene a workgroup of human services and health care advocates, legislative staff, and other specified representatives, to consider the feasibility, costs, and benefits of integrating application and renewal processes for additional human services and work support programs with the single state application described in the bill, and to provide, by July 1, 2013, specified details regarding the workgroup to the appropriate fiscal and policy committees of the Legislature. This bill would require that the functionality necessary to implement the cross-application process be achieved by the expiration of a specified federal waiver. This bill would provide that those provisions would become inoperative under certain circumstances.	**VETOED**
SB 1321 (Harmon) **Version:** As amended, May 30, 2012	**Exchange; essential health benefits: benchmark plan** This bill would require the board of the Exchange to determine the total cost of benefits for each health plan listed as an essential health benefits benchmark plan option in regulations adopted pursuant to the ACA. The bill would require that the plan with the lowest total cost of benefits set the benchmark for items and services to be included in the definition of essential health benefits under the ACA. The bill would also specify that its provisions shall only be implemented to the extent consistent with regulations adopted pursuant to the ACA.	**Location:** Senate Health

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BILL NUMBER	SUMMARY	BILL STATUS
SB 1431 (De Leon) **Version:** As amended, August 21, 2012	**Health insurance: stop loss coverage** This bill would require a stop-loss insurer, as defined, to offer coverage to all employees and dependents of a small employer to which it issues a stop-loss insurance policy and would prohibit the carrier from excluding any employee or dependent on the basis of actual or expected health status-related factors, as specified. Except as specified, the bill would require a stop-loss insurer to renew, at the option of the small employer, all stop-loss insurance policies. The bill would prohibit a stop-loss insurance policy issued on or after January 1, 2012, to a small employer from containing certain unspecified individual or aggregate attachment points, as defined, for a policy year or providing direct coverage, as defined, of an employee's health claims. The bill would make a stop-loss insurer in violation of these provisions subject to administrative penalties and would direct those fine and penalty moneys received to the General Fund to be available upon appropriation by the Legislature. The bill would, in addition, exempt the ongoing operation of MEWAs, as specified, from the operation of these provisions.	**Location:** Senate Inactive File
SB 1487 (Hernandez) **Version:** As amended, April 30, 2012	**Health Reform: Intent to implement Affordable Care Act provisions.** States legislative intent to enact into state law any provision of the Affordable Care Act that may be struck down by the United States Supreme court and is necessary to ensure that all Californians receive the full promise of the act.	**Location:** Senate Appropriations